DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
* 42 CFR 447 Subpart D

7. FEDERAL BUDGET IMPACT: See Attachment
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 566 - This amendment adjusts the distribution of disproportionate share monies, providing additional reimbursement to public hospitals, which transfer funds for federal matching.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 30, 2000

16. RETURN TO:
Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 11, 2000

18. DATE APPROVED:
September 21, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

* Pen and ink change made per State's 7-28-00 request.

Attachment to HCFA-179 for
Transmittal No. 00-01, Amendment No. 566

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Appendix 1 to Attachment 4.19-A	Appendix 1 to Attachment 4.19-A
Page 6	Page 6 (TN95-19)
Page 7	Page 7 (TN95-19)

Payments are made in the following manner, unless the state determines the hospital's proposed reimbursement has exceeded its adjusted hospital specific limit:

(1) A state chest hospital (facility of the Texas Department of Health) or a state mental hospital (facility of the Texas Department of Mental Health and Mental Retardation) that meets the requirements for disproportionate share status and provides inpatient psychiatric care or inpatient hospital services receives annually 100 percent of its adjusted hospital specific limit.

(2) For the remaining hospitals, payments are based on both weighted inpatient Medicaid days and weighted low-income days. The single state agency weights each hospital's total inpatient Medicaid days and low-income days by the appropriate weighting factor. The state defines a low income day as a day derived by multiplying a hospital's total inpatient census days from its fiscal year ending in the previous calendar year by its low-income utilization rate. Hospital districts and city/county hospitals with greater than 250 licensed beds in the state's largest MSAs would receive weights based proportionally on the MSA population according to the 1990 United States census. MSAs with populations greater than or equal to 150,000, according to the 1990 census, are considered as the "largest MSAs." Children's hospitals also receive weights because of the special nature of the services they provide. All other hospitals receive weighting factors of 1.0. The inpatient Medicaid days of each hospital are based on the latest available state fiscal year data for patients entitled to Title XIX benefits. The available fund is divided into two parts. One-half of the available funds reimburses each qualifying hospital on a monthly basis by its percent of the total inpatient Medicaid days. One-half of the available funds reimburses each qualifying hospital by its percent of the total low income days.

The department determines whether hospitals in rural areas will receive 5.5 percent or more of the disproportionate share hospital funds for non-state hospitals. If hospitals in rural areas will receive at least 5.5 percent of the gross non-state hospital funds, the department will reimburse them using existing principles. If hospitals in rural areas will not receive at least 5.5 percent of gross non-state hospital funds, the department will reimburse them at 5.5 percent of non-state hospital funds, using existing principles.

Reimbursement for the remaining hospitals is determined monthly as follows:

(1) The single state agency determines the average monthly number of weighted Medicaid inpatient days and weighted low-income days of each qualifying hospital.

(2) A qualifying hospital receives a monthly disproportionate share payment based on the following formula:

$$\left(\frac{1}{2} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Title XIX Days} * \text{Weight}}{\text{Total Avg. Mo. Weighted Medicaid Days}}\right)$$

+

$$\left(\frac{1}{2} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Low Income Days} * \text{Weight}}{\text{Total Avg. Mo. Weighted Low Income Days}}\right)$$

STATE Texas
DATE REC'D 07-11-00
DATE APPV'D 09-21-00
DATE EFF 09-01-00
HCFA 179 00-01

A

SUPERSEDES: TN - 95-19

(f) The specific weights for certain hospital districts and children's hospitals are as follows:

(1) Children's hospitals are weighted at 1.25.

(2) MSAs with populations greater than or equal to 150,000 and less than 300,000 are weighted at 2.75.

(3) MSAs with populations greater than or equal to 300,000 and less than 1,000,000 are weighted at 3.0.

(4) MSAs with populations greater than or equal to 1,000,000 and less than 3,000,000 are weighted at 3.25.

(5) MSAs with populations greater than or equal to 3,000,000 are weighted at 3.75

All MSA population data are from the 1990 United States census.

(g) The state or its designee determines the hospital specific limit for each disproportionate share hospital. This limit is the sum of a hospital's Medicaid shortfall, as defined in (b)(11), and its cost of services to uninsured patients, as defined in (b)(9), multiplied by the appropriate inflation update factor, as provided for in (h).

(1) The Medicaid shortfall includes total Medicaid billed charges and any Medicaid payment made for the corresponding inpatient and outpatient services delivered to Texas Medicaid clients, as determined from the hospital's fiscal year claims data, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, patients whose spell of illness claims were exhausted, or payments were denied due to late filing. (See definition for "Medicaid shortfall.")

The total Medicaid billed charges for each hospital are converted to cost, utilizing a calculated cost-to-charge ratio (inpatient and outpatient). The state or its designee determines that ratio by using the hospital's Medicare cost report that was submitted for the fiscal year ending in the previous calendar year. The state or its designee uses the latest available Medicare cost report in the absence of the Medicare cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part I, Column 25 and total charges from Worksheet C Part I, Column 6. The ratio is the total cost divided by the total gross patient charges.

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the fiscal year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges from reporting hospitals are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine the cost.

Hospitals that do not respond to the survey, or that are unable to determine accurately the charges attributed to patients without insurance, shall have their bad debt charges